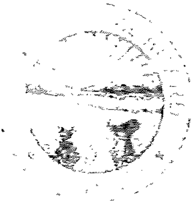

State Medical Board of Ohio

Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 11/18/2014
   Month Day Year

2. Name of medical practice or facility at which RU-486 was provided:
   PPOH

3. Address of medical practice or facility at which RU-486 was provided:
   3255 East Main St. Columbus, OH 43213

4. Date post RU-486 complication began: 12/09/2014

5. Event(s) (Please check all that apply):

   ✓ Incomplete abortion
   ___ Adverse reaction to RU-486
   ___ Patient hospitalized
   ___ Patient received a transfusion
   ___ Severe bleeding
   ___ Other serious event (specify) ______

6. Duration of event: NA Hours ______ Days

7. Remarks: failed medical Ab likely result of FDA protocol.

8. a. Name of physician who provided RU-486 Catherine Romanos MD

8. b. Physician's signature [signature] M.D./D.O

Date 12/9/14

Send completed forms to: State Medical Board of Ohio
Legal Department
30 E. Broad St., 3rd Floor
Columbus, OH 43215-6127

Prescribed: 5/--/2011, Rev. 12/13/12

MEDICAL BOARD
DEC 11 2014